

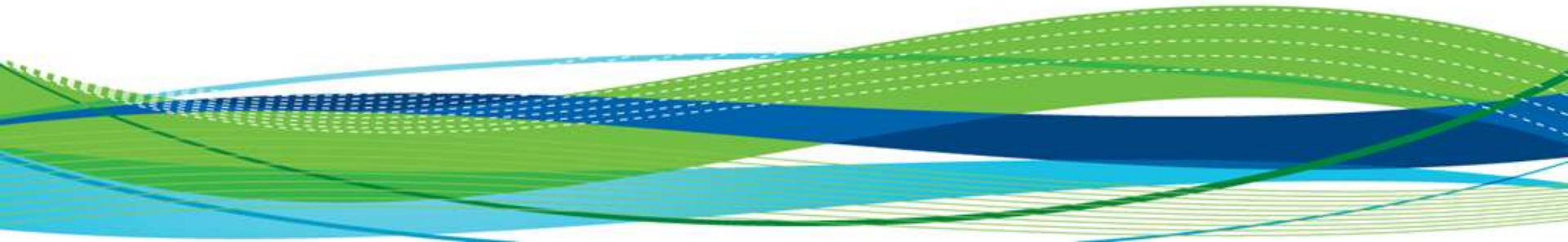
The Rural Health Landscape: The Only Constant is Change

14th Annual Hawaii Rural Hospital Conference

Brock Slabach, MPH, FACHE

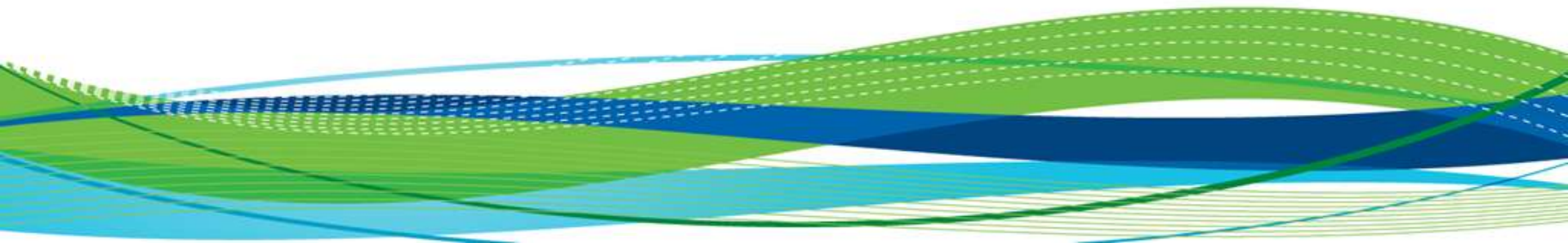
Senior Vice President for Member Services

National Rural Health Association

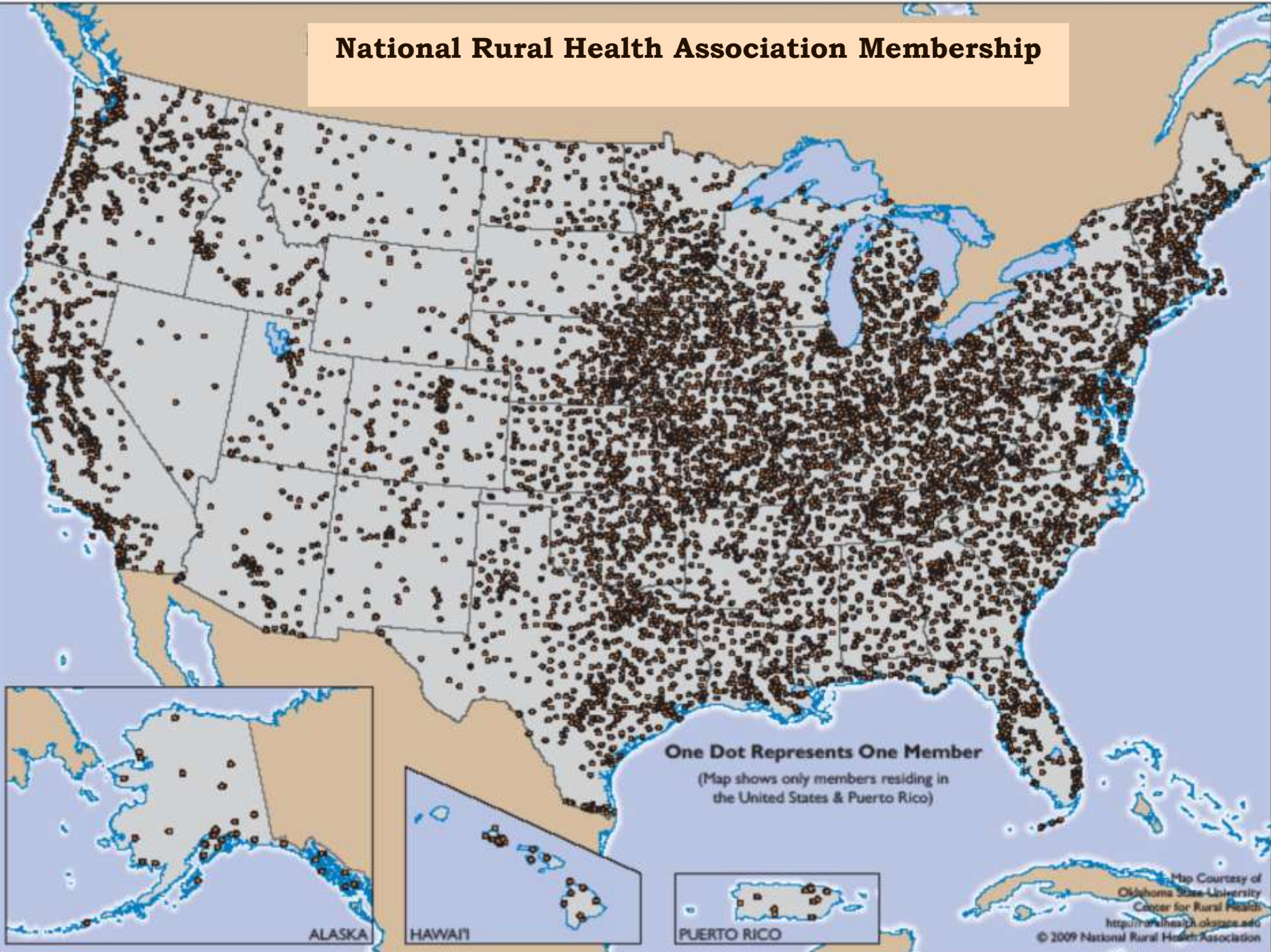


Improving the health of the 62 million who call rural America home.

NRHA is non-profit and non-partisan.



National Rural Health Association Membership



Our Grassroots Effort

- NRHA doesn't have a PAC
- Website: ruralhealthweb.org
- Depends solely on grassroots advocacy
- Members have access to:
 - ✓ Rural Health Blog
<http://blog.ruralhealthweb.org>
- Join NRHA today at ruralhealthweb.org

Destination NRHA



Plan now to attend these upcoming events.

Rural ACO Summit – Feb. 2, 2015 • Washington, D.C.

Rural Health Policy Institute - Feb. 3-5, 2015 • Washington, D.C.

Annual Conference – Apr. 14-17, 2015 • Philadelphia, PA

Quality Clinical Conference – Jul. 15-17, 2015 • Minneapolis, MN

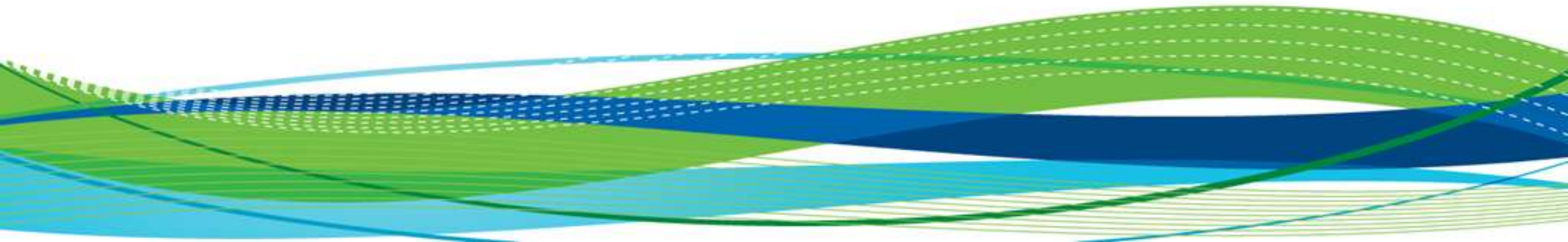
RHC/CAH Conference – Sept. 30- Oct. 2, 2015 • Kansas City, MO

**Visit RuralHealthWeb.org
for details and discounts.**

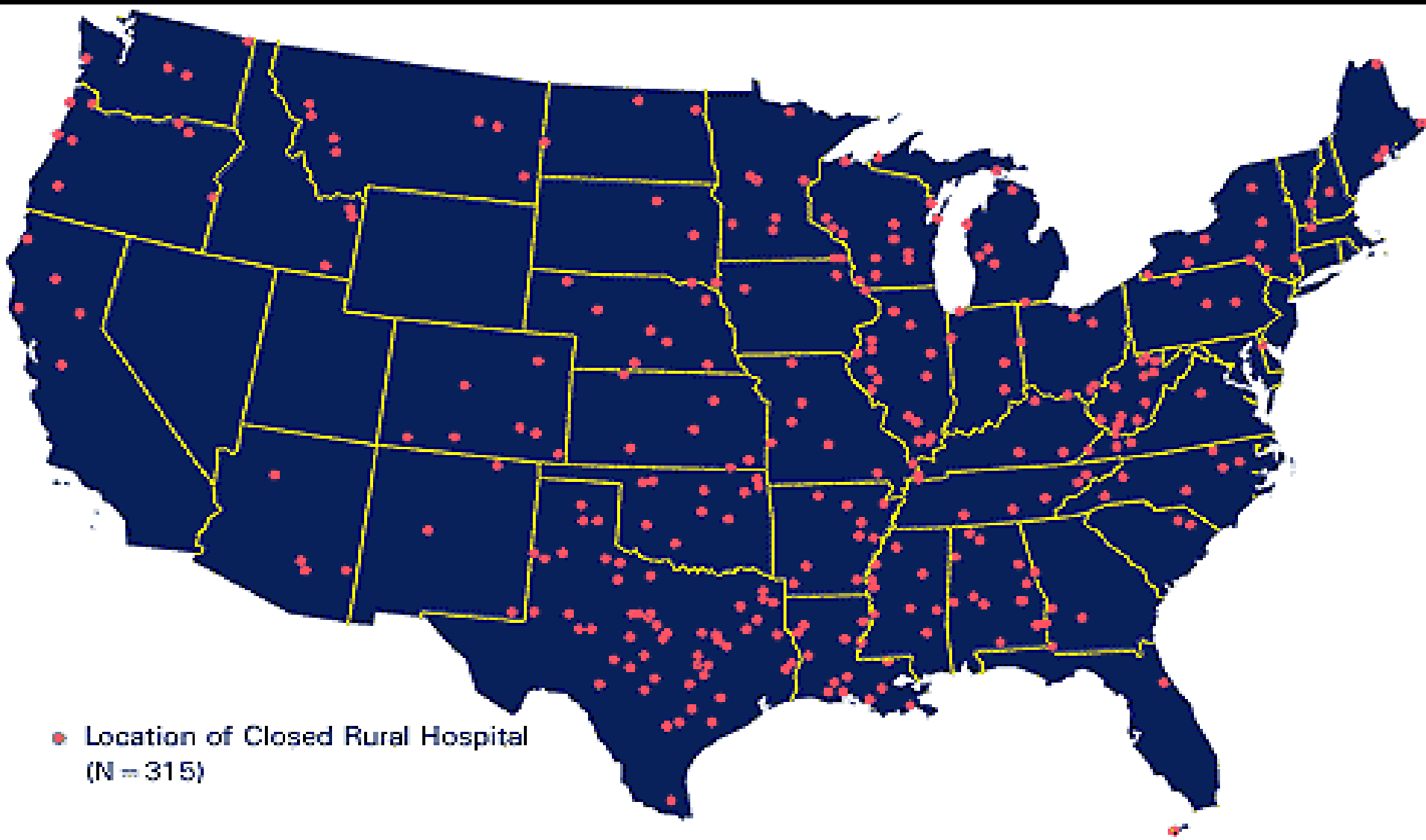
Rural disparities/challenges



- War on Poverty in the 60's
- Community Health Centers, created in the War on Poverty
- Rural Health Clinics –just turned 36 (1978), >4,500 RHC's nationwide
- Advent of PPS 1983: 440 hospital closures 1987-1997
- Policy Response: SORH, Flex, MDH, CAH and LVH
- Rural serves more challenging populations:
- “Rural Americans are **older, poorer and sicker** than their urban counterparts... Rural areas have higher rates of poverty, chronic disease, and uninsured and underinsured, and millions of rural Americans have limited access to a primary care provider.” (HHS, 2011)
- Disparities are compounded if you are a senior or minority in rural America.



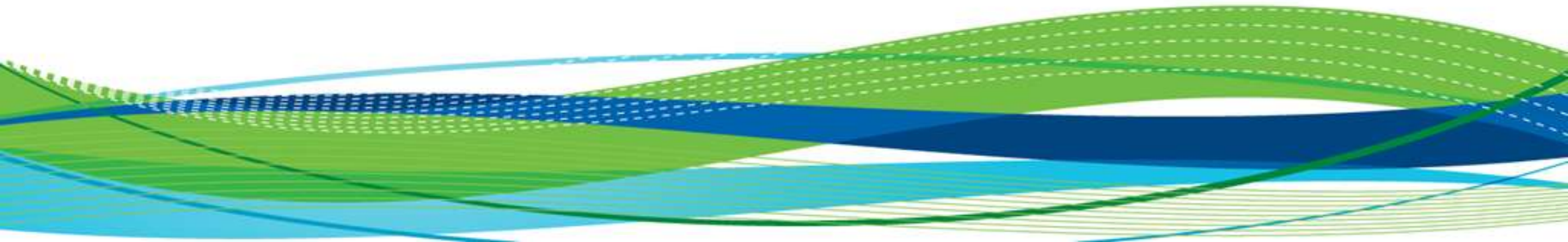
Rural Hospital Closures: 1983-97



Problems still exist...



- *Health equates to wealth* according to Univ. of Washington Study, July 2013
- Key Finding:
- The study found that people who live in wealthy areas like San Francisco, Colorado, or the suburbs of Washington, D.C. are likely to be as healthy as their counterparts in Switzerland or Japan, but those who live in Appalachia or the rural South are likely to be as unhealthy as people in Algeria or Bangladesh.

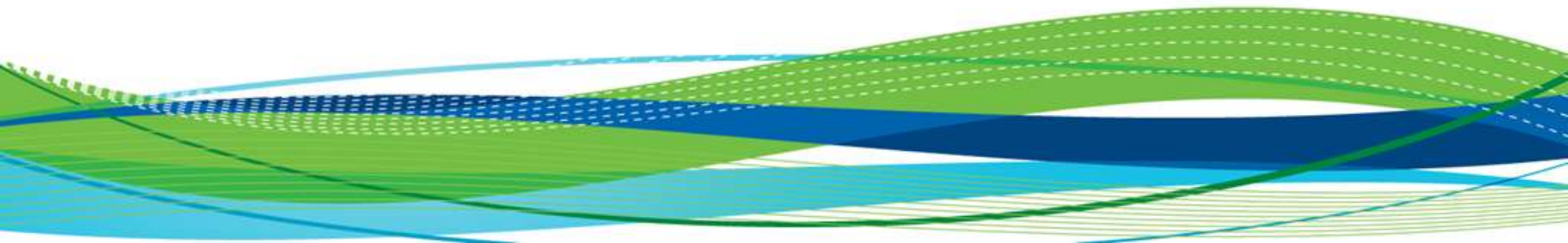


Federal Deficit Trends

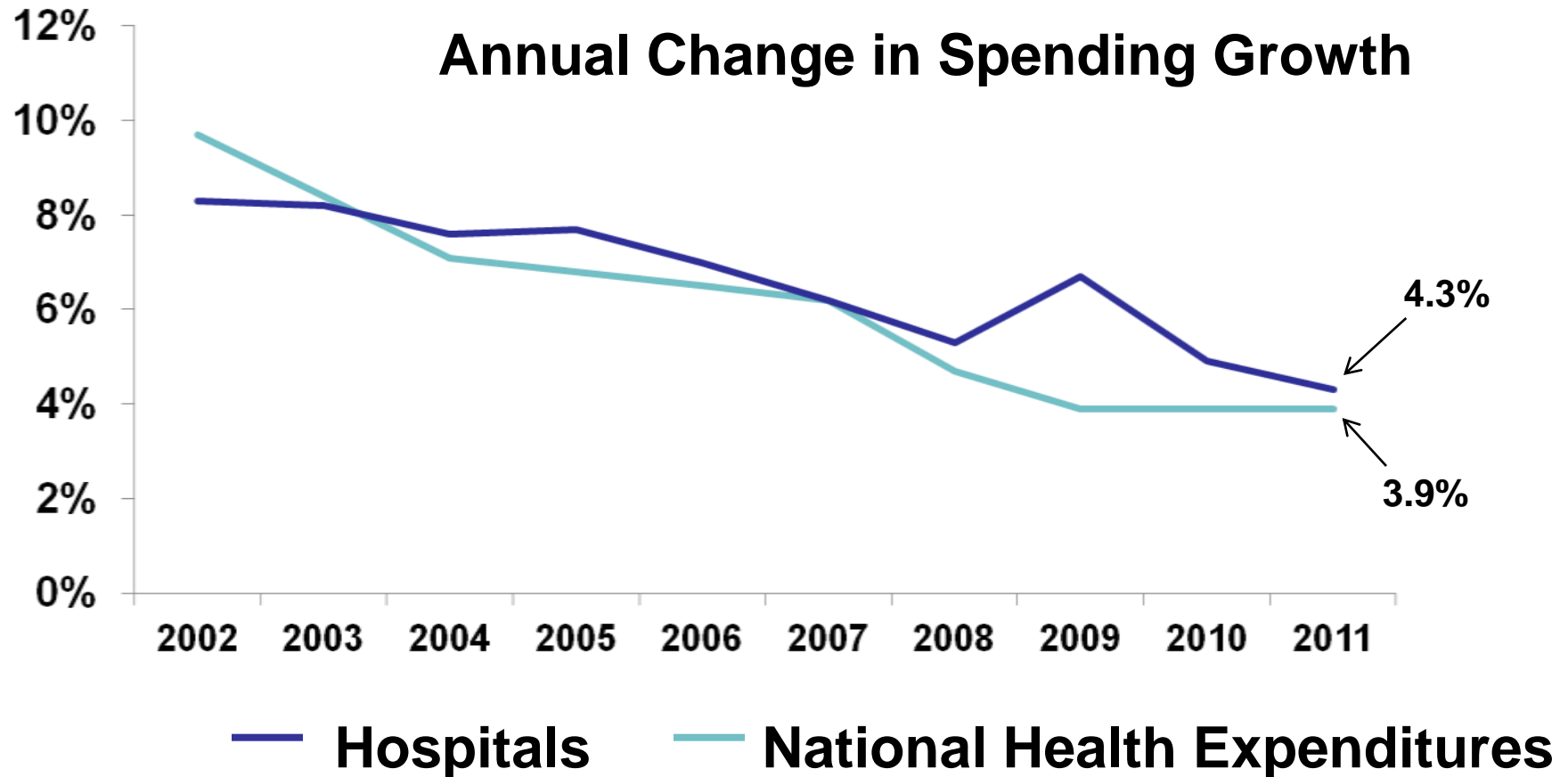


- FY 2009 Deficit: \$1.4 Trillion
- FY 2014 Deficit: **\$514 Billion**
- 2014 Debt Level is 3% of GDP
- This 3% is the average for the last 40 years
- Anticipated debt in FY 2015: **\$478 Billion**

Source: CBO

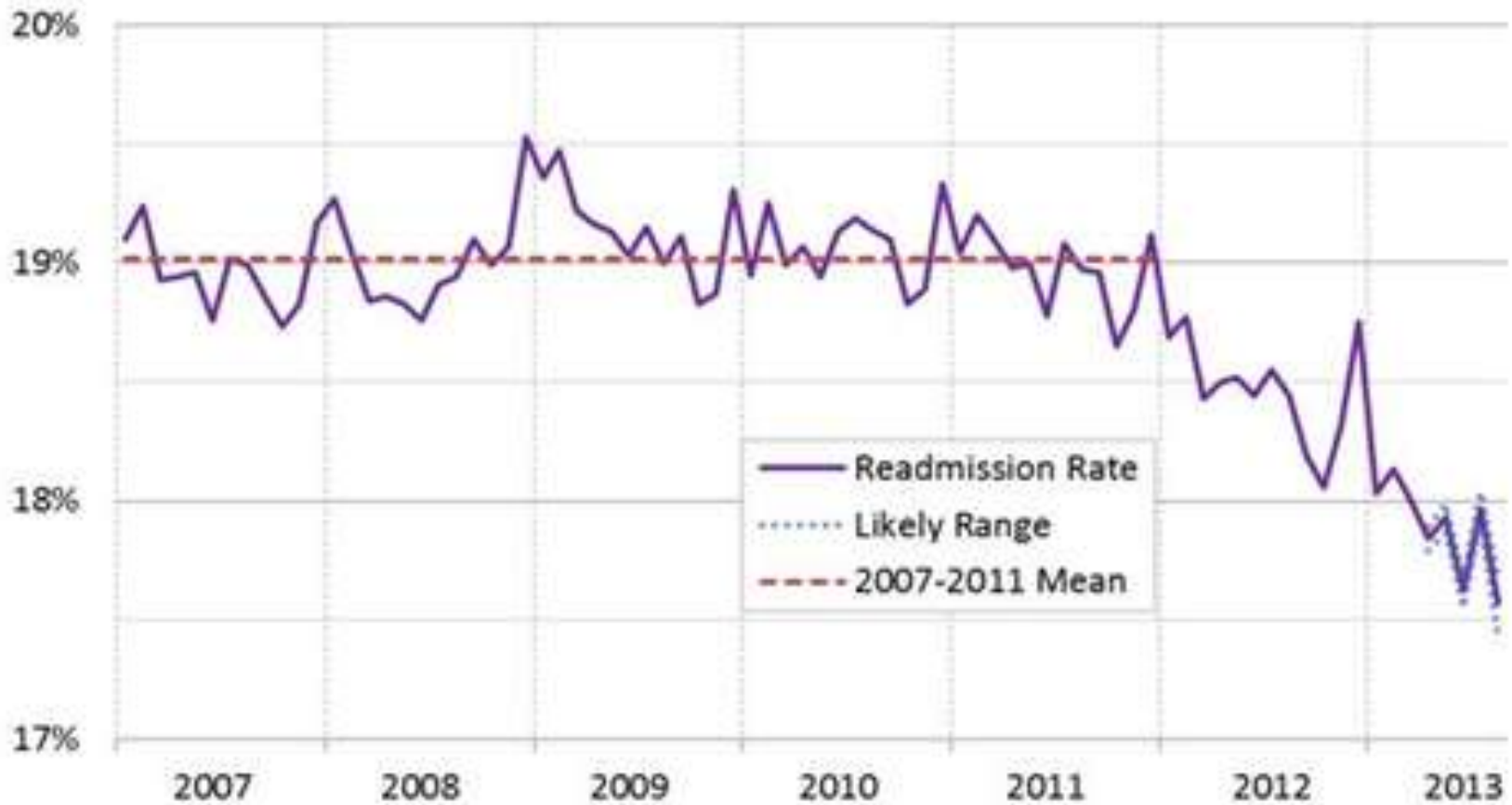


Slowdown In Health Cost Growth



Source: CMS OACT National Health Statistics Group; Historical Tables.

Monthly Medicare 30-Day, All-Condition Hospital Readmission Rate January 2007 - August 2013



CMS: 2,610 PPS hospitals to receive penalties in 2015

Source: Centers for Medicare and Medicaid Services, Offices of Enterprise Management

A Metastasizing Crisis

- 27 rural hospitals closures since 2013.
- More closures in 19 months than total between 2003 and 2012 combined.
- Rate will likely double in 2015.





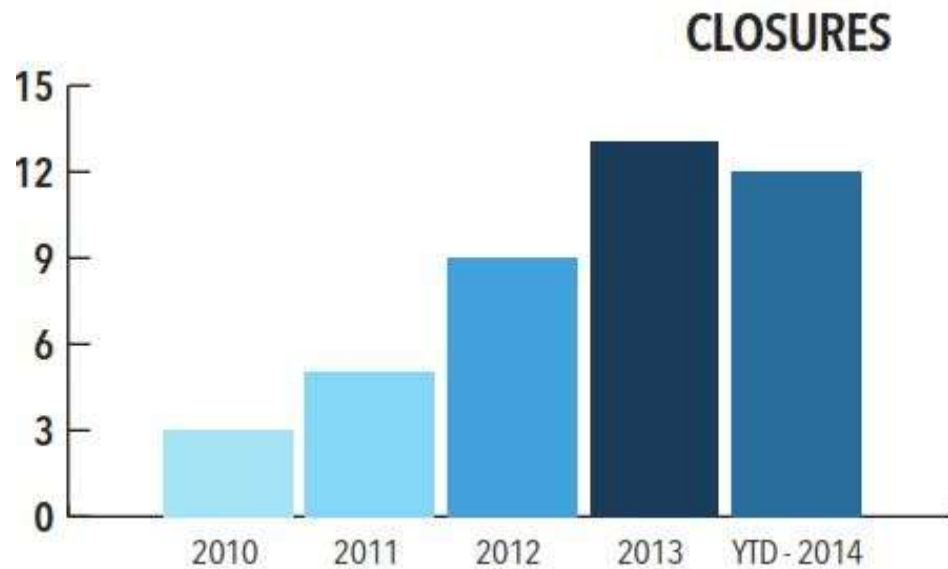
CLOSED

**“When rural hospitals close,
towns struggle to stay open.”**



Marketplace, April 2014

Rural Hospital Closures



283 Hospitals Vulnerable

iVantage identifies 283 rural hospitals that match the performance of the 26 forced to close already this decade.

Rural Hospital Closures Escalating



RURAL HOSPITAL CHALLENGES

↓ Sequestration

↓ Volumes

↓ Reimbursements

RURAL VS. URBAN



In each year from FY11 to FY13, rural hospitals posted a median operating profit margin that was at least 1.66 percentage points lower than that of urban hospitals, and the gap is widening.

Source: Rural Relevance Under Healthcare Reform (2014 HCRIS)

Impact of 283 Hospital Closures



700,000

Patient Encounters



36,000

Healthcare Jobs Lost



50,000

Community Jobs Lost



\$10.6 Billion

Loss to GDP

“Rural hospitals and the rural economy rise and fall together”



- On average, 14% of total employment in *rural areas is attributed to the health sector. Natl. Center for Rural Health Works. (RHW)*
- The average CAH creates 107 jobs and generates \$4.8 million in payroll annually. (RHW)
- Health care often represent up to 20 percent of a rural community's employment and income. (RHW)
- A rural physician generates 23 jobs in the local economy

“Three years after a rural hospital community closes, it costs about \$1000 in per capita income.”

Mark Holmes, professor,
University of North Carolina

“The Real Loser of the Recession is Rural America”



The Washington Post, Nov. 2013 **Your voice. Louder.**

No net employment growth in nonmetro counties in 2012 and first half of 2013

Employment index (2008 Q1 = 100)



Notes: Local Area Unemployment Statistics (LAUS) estimates cover both wage and salary workers and the self-employed. Metro and nonmetro counties are as identified by the Office of Management and Budget in 2013. New population controls were introduced into the LAUS data following the April 2010 Census, leading to an increase in estimated employment in the second quarter of 2010. The data shown have been corrected to compensate for this change, but caution should be used in comparing levels before and after this date.

Source: USDA-ERS analysis of Bureau of Labor Statistics-LAUS data, seasonally adjusted by ERS.

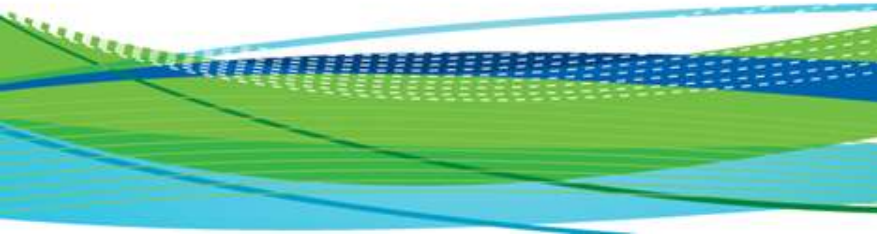
- Recession caused significant job loss in rural areas, followed by out-migration of young, healthy individuals from rural areas.
- 90% of permanent job loss since recession is in non-metropolitan counties (Daily Yonder)



What Happens When a Town's Only Hospital Shuts Down?



- “It was a tragedy that stunned a small Texas town: 18-month-old Edith Gonzales, a grape lodged in her tiny throat, died in her desperate parents’ arms because the county’s only hospital and emergency room had closed for good a few months earlier.” *US News and World Report*, Nov. 2013
- “The toddler’s Aug. 12 death has starkly exposed the vulnerabilities of a rural community suddenly left without its longtime safety net.” *Dallas News*, Nov. 2013



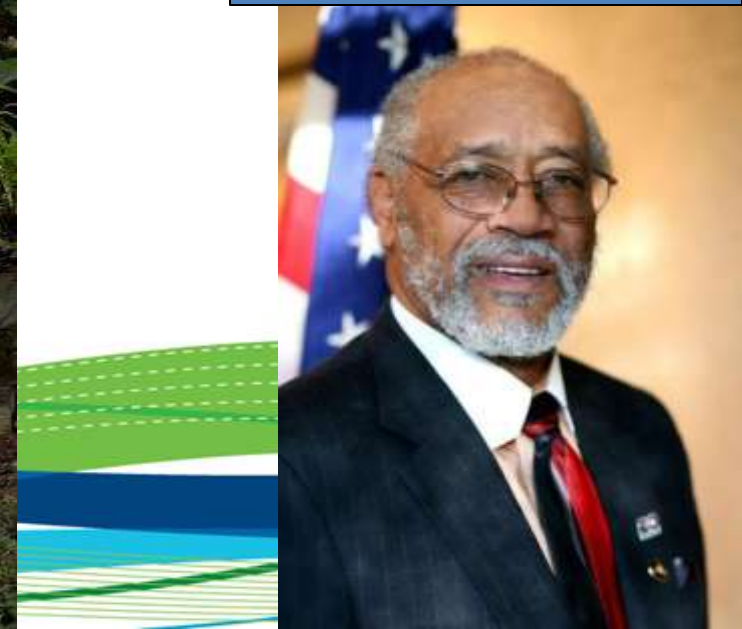
It's about the patients...

“Only four days after the Pungo District Hospital in Belhaven closed its doors for good on July 1, Portia Gibbs, 48, suffered a heart attack and died just as the chopper arrived to airlift her to a hospital. . ***“In that hour that she lived, she would have received 35 minutes of emergency room care, and she very well could have survived,”*** Belhaven Mayor Adam O’Neil.

(Nearest hospital is now 75 miles away.)

“[It] ends up with rural communities, such as Hancock County (Georgia), where 39 percent of the folks who have a stroke or have a heart attack die. That’s a lot higher than in counties with hospitals close by.”

David Lucas, Georgia State Senator.

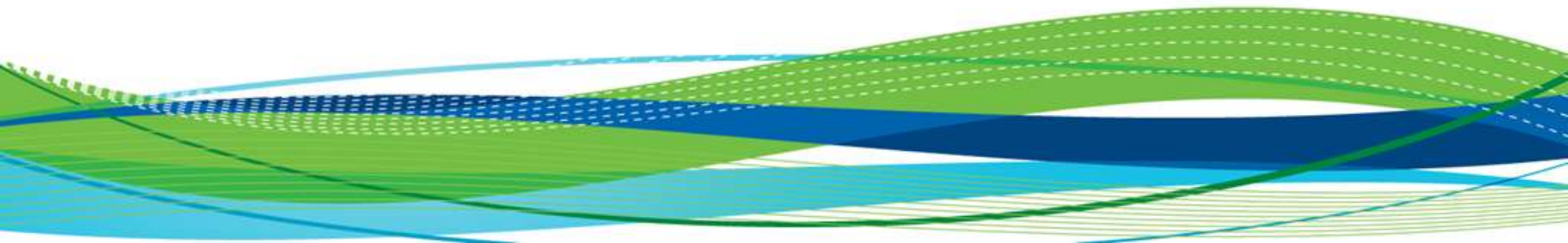


It's about access to care...



- 5,700 hospitals in the country; only 35 percent are located in rural areas.
- 640 counties across the country **without** quick access to an acute-care hospital. *UNC Sheps Center*
- “Access to care remains the number one concern in rural health care.” Rural Healthy People
- [The closings] “are a growing problem of ‘**medical deserts**’...it is much like the movement of a glacier: nearly invisible day-to-day, but over time, you can see big changes.”

Alan Sager, Boston Univ. professor of health policy

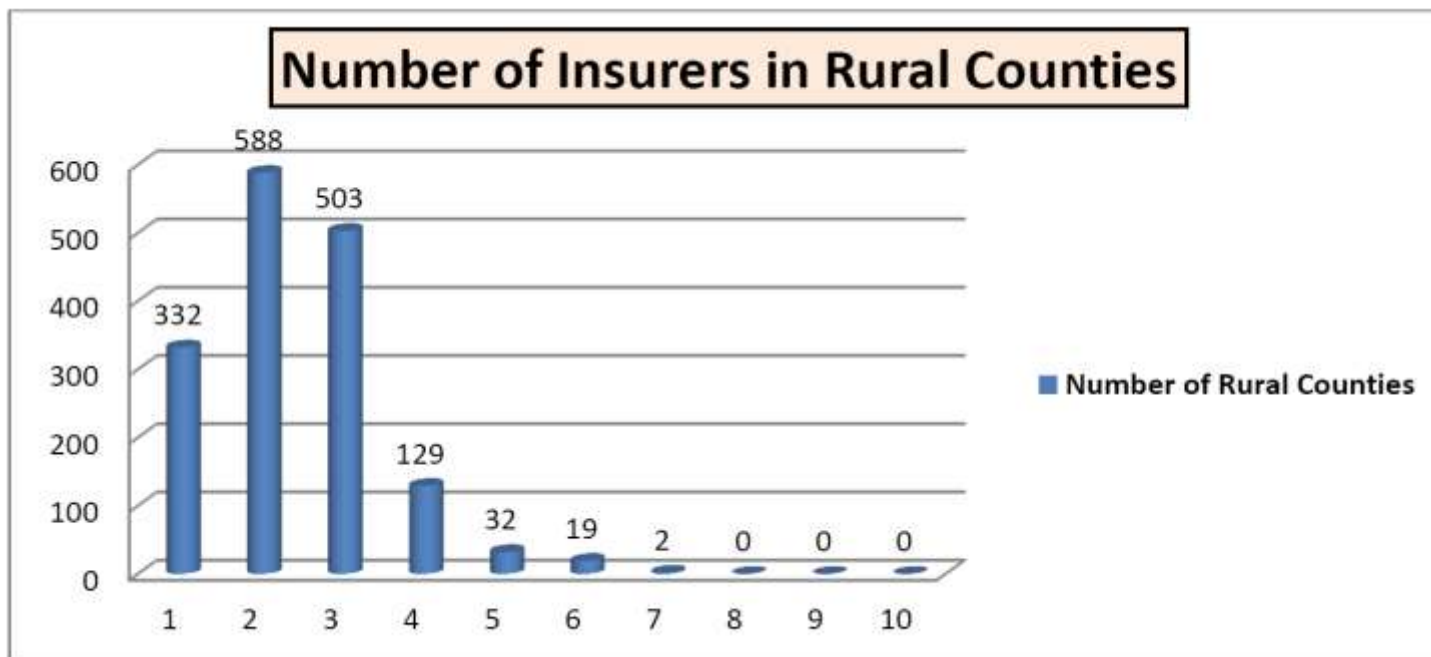


Are Health Exchanges Working in Rural Areas?



Your voice. Louder.

- 58.3% of rural counties only had 1 or 2 plan options
- 23.7% of rural counties vs. 5.5% of urban counties had only 1 plan option
- Over $\frac{3}{4}$ of urban plans had three or more choices of coverage



Rural areas appear to have lower rates of plan selection, suggesting that improving outreach and enrollment efforts in these communities may be particularly warranted.

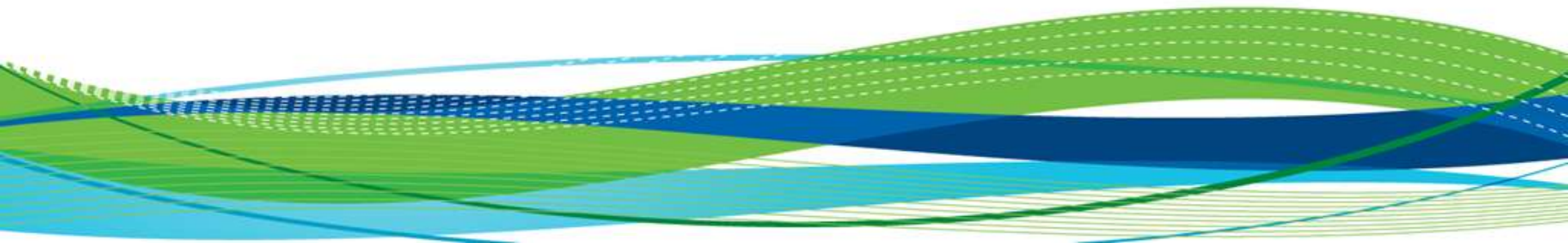
Sept. 2014



Other Health Exchange Concerns



- Are you an “essential community provider”?
Are you in a narrow network?
- What is the deductibility of your patients’ plans?
- DSH and uncompensated care deductions in ACA disproportionately harm rural providers.



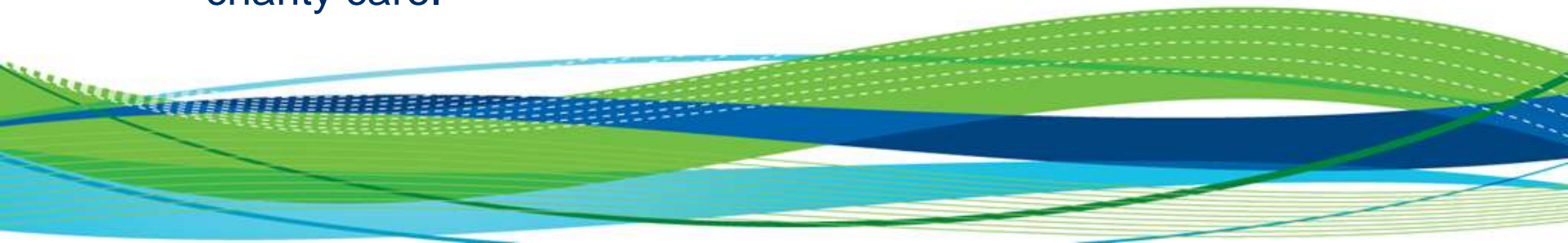
Can rural Americans afford ACA Coverage?



- 36% of uninsured indicated “high cost” of coverage as their primary reason for remaining uninsured.
- 65% of plans selected in first year were silver plans. Average silver deductible is **\$2,907** (often higher out of pocket cost for prescriptions than employer-based plans).
- Average deductible for a bronze plan is **\$5,081**.
- (52% of Americans have less than \$3000 in non-retirement savings.)

Can Rural Providers afford ACA?

- RHCs and CAHs will have to absorb more bad debt and charity care.



Narrow Networks and Lack of Transparency



- There are 3 times as many narrow networks in 2014 than 2013 (those with coverage of 14 or 14 of an areas 20 largest hospitals)
- 70 percent of ACA plans analyzed had narrow or ultra-narrow networks.
- Consumers report misinformation or incomplete information about providers in network
- Of the nation's top 18 hospitals, as ranked by US News and World Report, only 11 accept one or two carriers' exchange plans

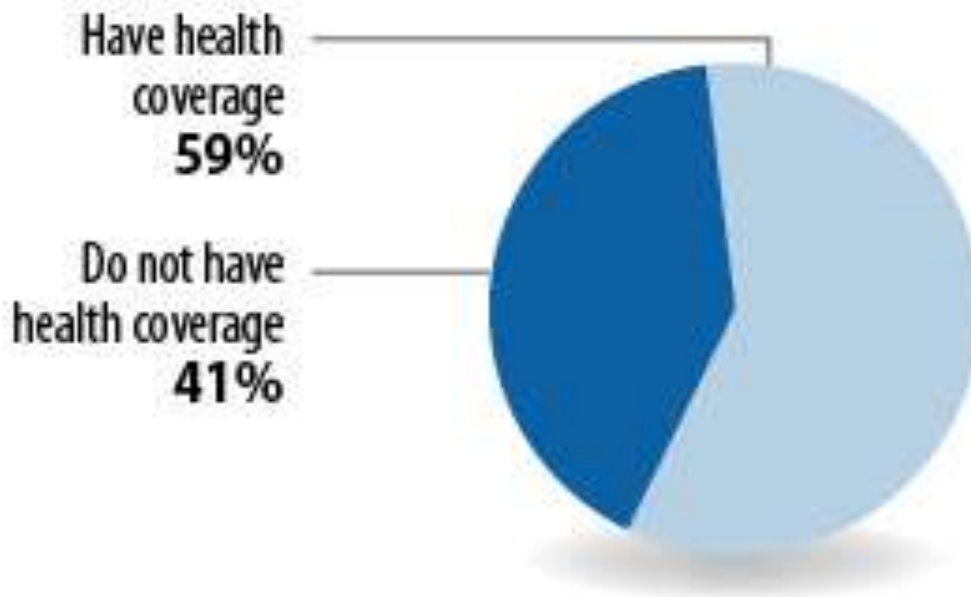


Sept, 2014 Senate R Report

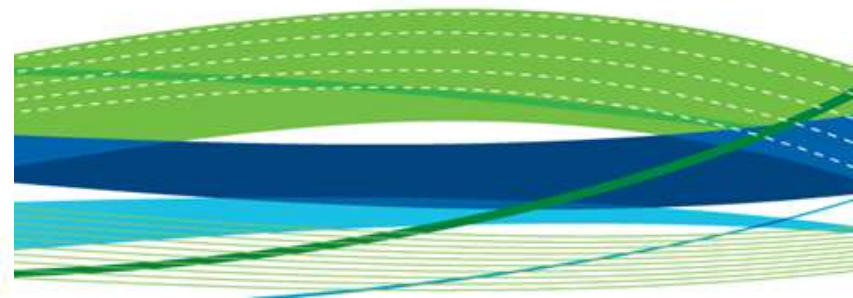
Pre-ACA

More Than 2 in 5 Low-Income Non-Elderly Adults in Rural America Lack Health Coverage

6.4 million non-elderly adults are under 138% of the poverty line



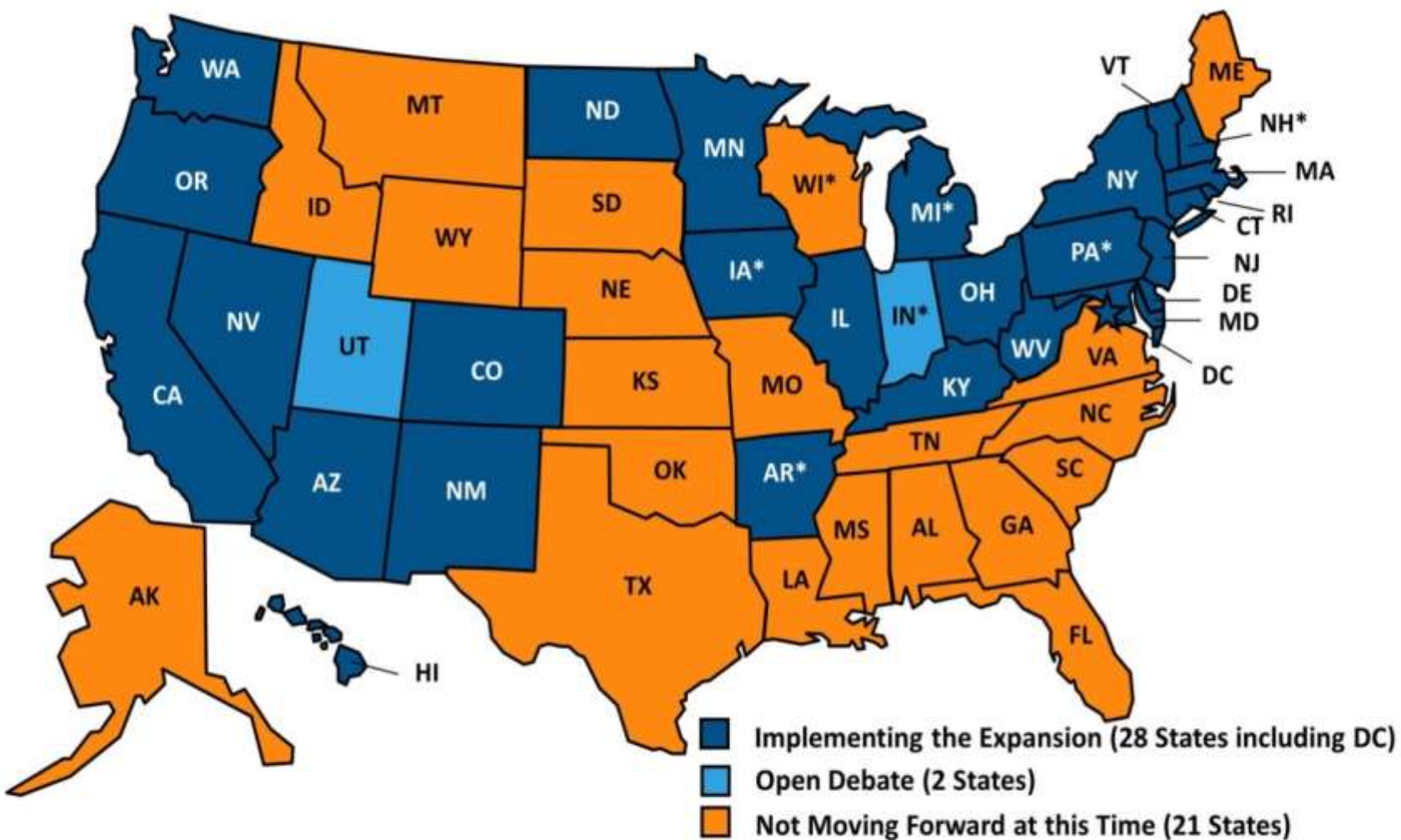
- Physicians in rural areas receive 20 percent of their revenue from Medicaid, compared with 17 percent for physicians in urban areas.



Source: CBPP analysis using 2012 Census Bureau data

Center on Budget and Policy Priorities | cbpp.org

Current Status of State Medicaid Expansion Decisions



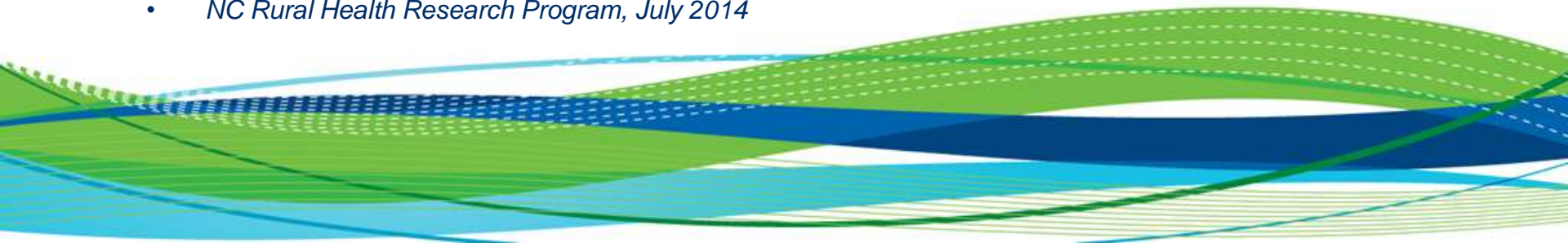
NOTES: Data are as of August 28, 2014. *AR, IA, MI, and PA have approved Section 1115 waivers for Medicaid expansion. In PA, coverage will begin in January 2015. NH is implementing the Medicaid expansion, but the state plans to seek a waiver at a later date. IN has a pending waiver to implement the Medicaid expansion. WI amended its Medicaid state plan and existing Section 1115 waiver to cover adults up to 100% FPL in Medicaid, but did not adopt the expansion.

SOURCES: Current status for each state is based on data from the Centers for Medicare and Medicaid Services, available [here](#), and KCMU analysis of current state activity on Medicaid expansion.

How Does Medicaid Expansion Affect Insurance Coverage of Rural Populations



- A majority of the states with the largest percentage of population living in rural areas are not expanding, while nearly all of the least rural states are expanding.
- Rural, poor states are the least likely to expand Medicaid.
- The majority of rural residents in the U.S. live in states that are not expanding. Only 3 of the 11 states with the largest rural population have expanded (IA, KY, MI)
- There is a wider rural-urban insurance coverage that existed pre-ACA.
- *NC Rural Health Research Program, July 2014*





Medicare cuts enacted so far:

- Sequestration cuts – 2% for nine years
- Bad Debt Reimbursement cuts
- Documentation & Coding cuts
- Readmission cuts
- Multiple therapy procedure cuts
- ESRD reimbursement cuts
- Super rural laboratory extender – expired
- Outpatient hold harmless payments (TOPS) – expired
- 508 reclassifications – expired

Impact of Sequestration



- Loss of over \$1billion in rural revenue.
- Tens of millions of dollars lost for rural PPS hospitals.
- 41% of rural hospitals operate at a financial loss; sequestration will force many more into the red.
- SGR Patch – pay-for; extends non-discretionary sequestration years.
- Result:
 - * Rural Job losses;
 - * Rural revenue lost
 - * Rural patient services cut
 - * Possible rural hospital closures

OIG Report Attacks CAHs



- 846 CAHs would not meet the distance requirement if required to re-enroll
 - 306 were located 15 miles or fewer to a nearest hospital.
 - 235 were between 10-14 miles from nearest hospital.
 - 71 were less than a 10-mile drive.
- If fully implemented; complete crippling of the rural health system.
- 70%, 80%, even 90% of rural hospitals in certain states impacted.

Office of Inspector General



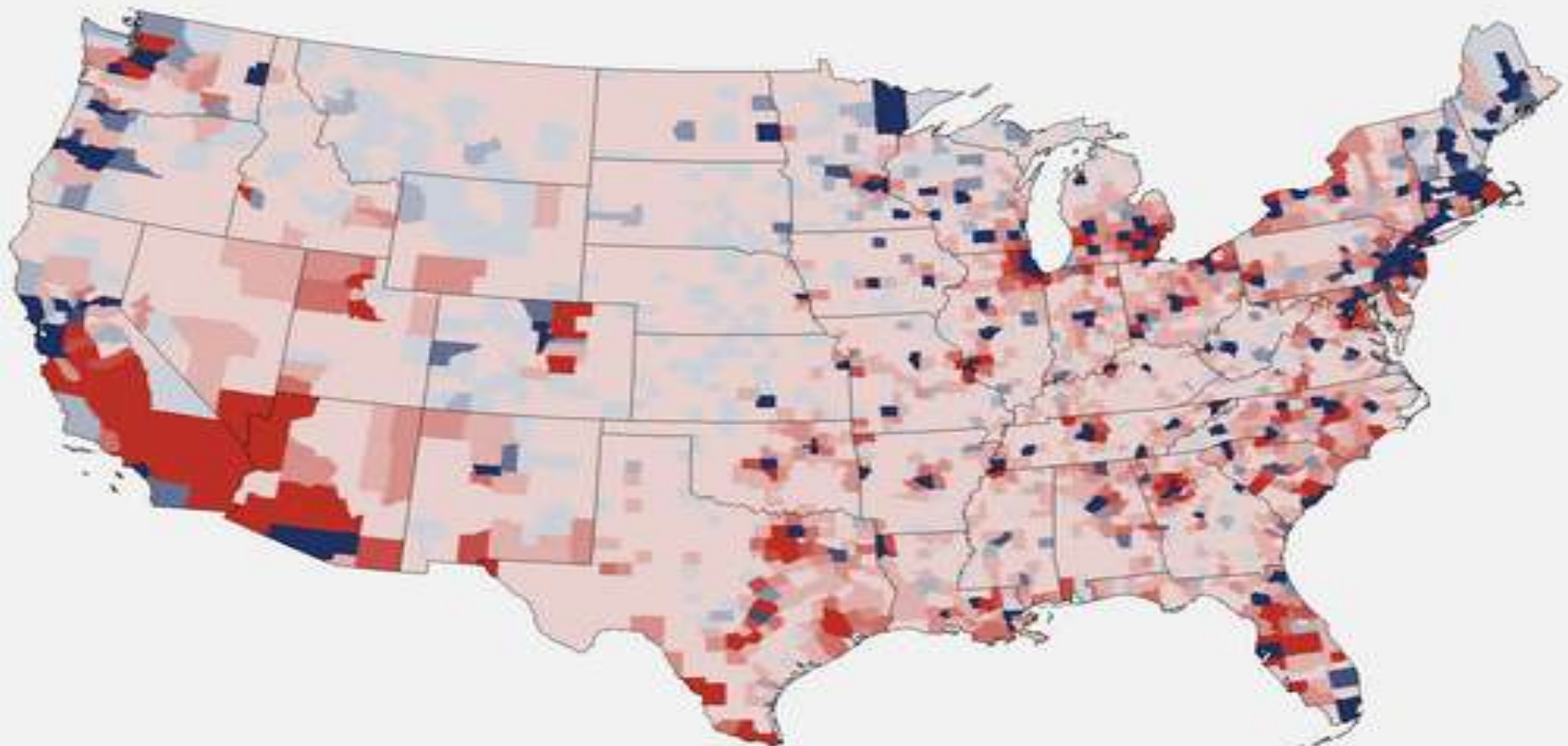
Health and Human Services

Rural and Urban Comparison of Operating Margin

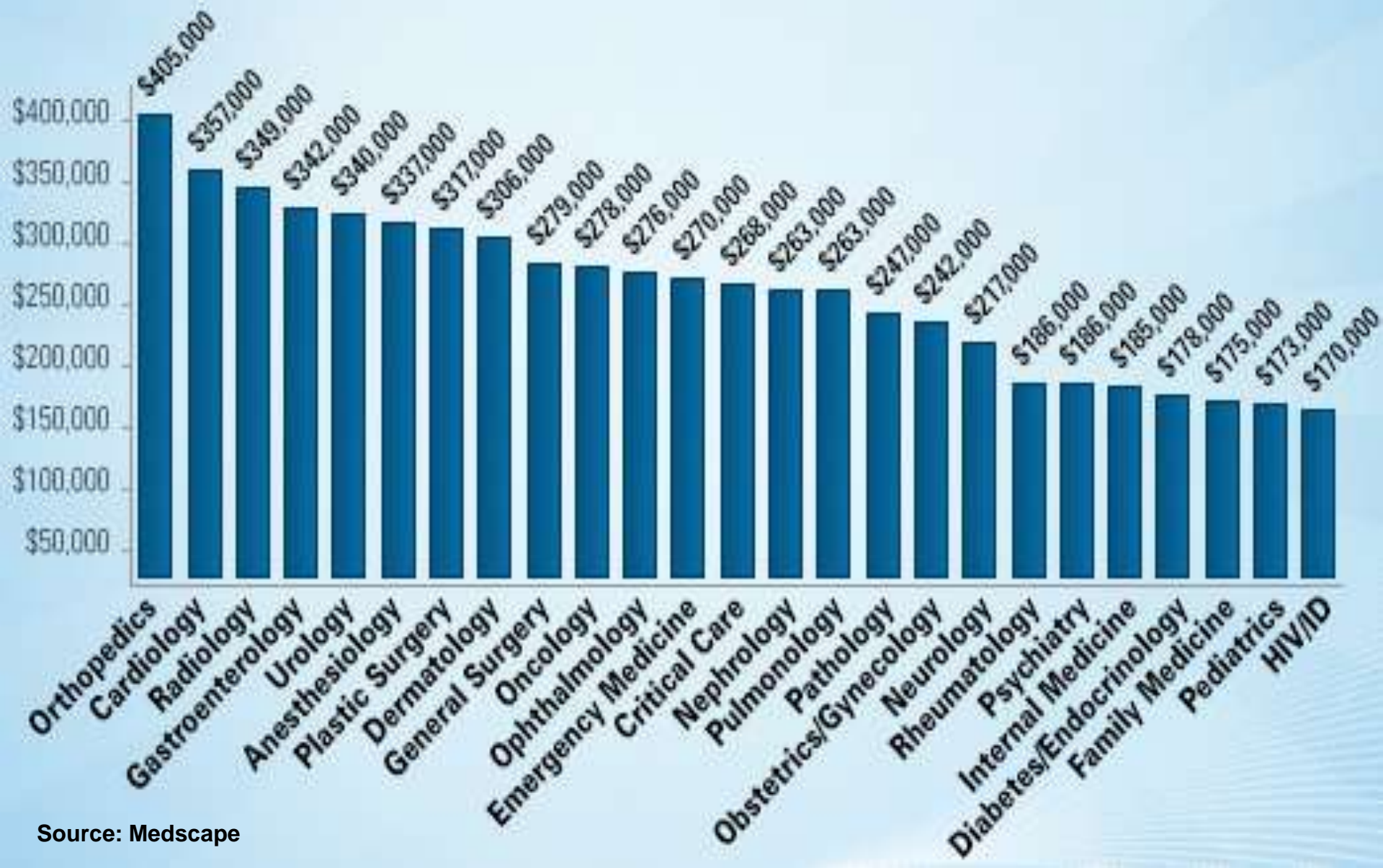


	Profitable	Switch	Unprofitable	Grand Total
All Rural	739	44	1,540	2,323
CAH	363	26	927	1,316
Medicare Dependent	62	8	147	217
Sole Community	173	7	262	442
Standard Rural PPS	141	3	204	348
Urban	1,166	42	1,157	2,365
Grand Total	1905	86	2,697	4,688

Nationwide Shortage and Surplus of Primary Care Physicians



Physician Compensation in 2012



Key Issues



Your voice. Louder.

- Protection from burdensome and excessive policies
 - Physician Supervision
 - 96 Hour Certification Rule in CAH's
 - Two-midnight Policy
 - CAH vs PPS Outpatient Coinsurance: OIG Report
- Protect [340B Program](#)
- Trends in Hospital Affiliations: RUPRI Policy Brief
- ACO Regulations for CAH and rural providers
- Public Health—Ebola, Enterovirus D68

CDC Ebola Guidelines

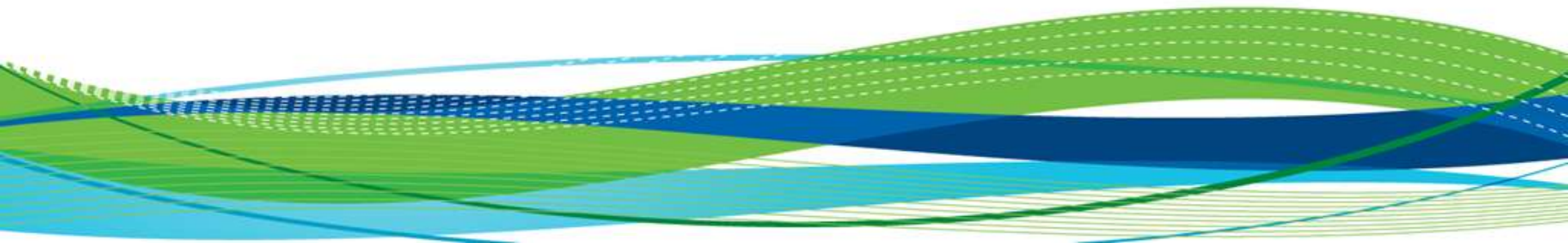


- Prior to working with an Ebola patient, staff should undergo rigorous training and practice, and demonstrate competence in safely putting on and removing PPE
- No skin should be left exposed when PPE is worn
- A trained observer should watch every time personnel put on and remove PPE
- New [CDC Fact Sheet](#)

Key Issues



- Protect/Enhance Provider Payments
 - CAH's
 - PPS Hospitals
 - Physicians
 - Veteran's access to rural providers
 - Meaningful Use Stage 2
 - Rural Health Clinic (RHC) Program
 - Federally Qualified Health Center (FQHC)
 - Population Health
 - Tele-health Opportunities



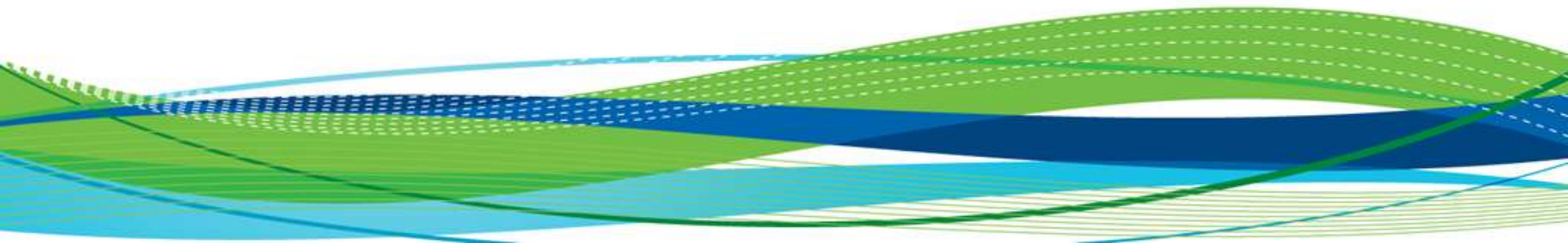
Tele-health Opportunities

- CMS Regulation expanded coverage for these services using tele-health:
 - Wellness visits
 - Behavioral health
 - Allow these payments in “rural census tracts”
- Surveyor Guidelines for CAH ED Physician services

Why is there an assault on rural health care?



- Loss of champions;
- New members who don't know why certain rural payments exist;
- Strong fiscal conservative movement;
- CMS negative attitude toward CAHs;
- Confusing rural payment system - - many see payments as “bonuses”



Rural champions exit Congress



Many other rural champions are also leaving or have left – Sen. Harkin (D-IA), Sen. Rockefeller (D-WV), Sen. Inouye (D-HI), Sen. Conrad (D-ND), Sen. Bingaman (D-NM), Sen. Lugar (R-IN), Sen. Snowe (R-ME)

Senator Max Baucus (D-MT) – Staunch rural health advocate, now Ambassador to China

- CAH program
- Rural primary care programs
- Rural demonstration projects

NOTE: Sen. Ron Wyden (D-OR) is now

- Finance Committee Chairman.



Legislative Success

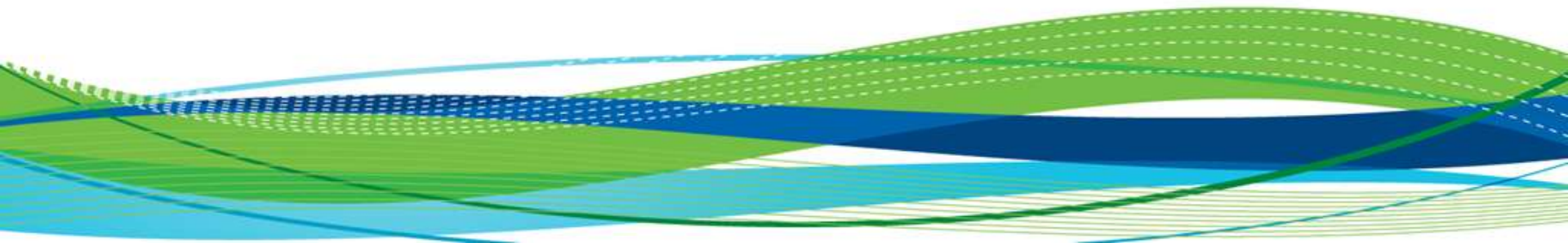
- **Protecting Access to Medicare Act of 2014 (PAMA)**
Signed into law on April 1, 2014
 - SGR Fix preventing 24% to Medicare FFS payments
 - MDH and LVH
 - GPCI Rural Floor
 - These provisions extended for only 1 year or March 31, 2015...déjà vu all over again
 - ICD-10 Delay, now Oct. 1, 2015
 - Delay Medicaid DSH Cuts for 1 year (2017)

How NRHA is Fighting Back



Our Campaign:

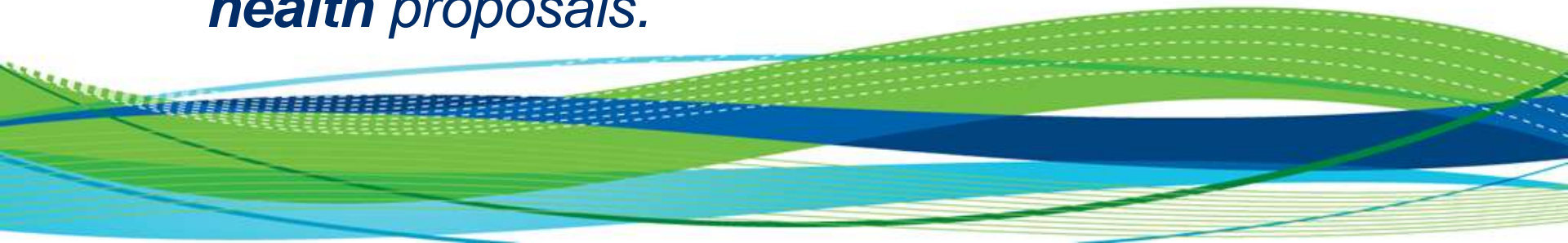
1. Stop the bleeding. Halt additional proposed cuts to rural hospitals from the Administration and Congress immediately. Support pro-rural provisions such as Medicaid expansion, elimination of the 2% sequestration cuts and 101% reimbursement for CAHs to stabilize the rural safety net.
2. Build bridge to the future. Promote new provider payment models to create a new rural reality.



To accomplish our goals: Three strategies



- 1.) *Raise public awareness: launch national Fall media campaign*
- 2.) *Develop and introduce new legislation to **stabilize rural hospitals.***
- 3.) *Develop and promote **the future of rural health** proposals.*



The CARE Act

(Community Access and Rural health Equity Act)



- Elimination of Medicare Sequestration for rural hospitals
- Reversal of all “bad debt” reimbursement cuts
- Establish permanency of Medicare Dependent Hospital Program
- Establish permanency of Low-Volume Hospital Adjustment
- Reinstatement of Sole Community Hospital “Hold Harmless”
- Exception from “Documentation and Coding” cuts established in various legislation
- Establishment of Meaningful Use support payments
- Elimination of the CAH 96-Hour Condition of Payment
- Rebase of supervision requirements for outpatient therapy services at CAHs and rural PPS facilities
- Demonstration program funding for new delivery models
- CAH Outpatient Coinsurance equity

How do you fight back?



Tell your story.

Our message is powerful.
An investment in rural
health:

1. Protects patients;
2. Protects the rural economy; and
3. Protects taxpayers



Legislation to Support



Your voice. Louder.

Rural Hospital Access Act	S. 842 and H.R. 1787
Rural Hospital and Provider Equity Act R-HoPE	S 2359
Strengthening Rural Access to Emergency Services Act	S. 328
Extension of FESC Demonstration	S. 239
Senate Resolution on importance of rural health providers	S.R. 26
Rural Hospitals are Essential Act	H.R. 356
The DSH Reduction Relief Act	S. 1555 and H.R. 1920

Legislation to Support



The Medicare Audit Improvement Act	S. 1012 and H.R. 1250
The Two-Midnight Rule Delay Act	H.R. 6398
Protecting Access to Rural Therapy Services Act	S. 1143 and H.R. 2801
Critical Access Hospital Relief Act	HR 3991 and S. 2037
Two-Midnight Rule Coordination and Improvement Act of 2014	S 2082
Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act)	S 2553 and HR 4994

Questions?

THANK YOU

Brock Slabach, MPH, FACHE
Senior Vice President for Member Services
National Rural Health Association
bslabach@nrharural.org